California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
Website: www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

PHARMACY TECHNICIAN REGISTRATION
APPLICATION AND REQUIREMENTS

A PHARMACY TECHNICIAN is an individual who, under the direct supervision and control of a pharmacist, performs packaging, manipulative, repetitive, or other non-discretionary tasks related to the processing of a prescription in a licensed pharmacy, but excludes all functions restricted to a registered pharmacist. To work as a pharmacy technician in California, you must possess and keep current registration as a pharmacy technician.

It takes approximately eight weeks to issue a pharmacy technician permit after submission of a complete application package. The board will notify you if it needs additional information.

Effective January 1, 2000, an applicant for registration as a pharmacy technician must be a high school graduate or possess a general education development (GED) equivalent AND meet one of the qualification methods (described below). If you were registered as a pharmacy technician in the past and are reapplying, you must meet the educational requirement.

HOW TO APPLY TO BECOME A PHARMACY TECHNICIAN

Your application must include:

- A non-refundable fee of $50.
- A completed pharmacy technician application (17A-5), with all questions answered. You must sign this form and attach a photograph.
- A copy of **Request for Live Scan Service Form** verifying that your fingerprints have been scanned and all applicable fees paid. (See instruction below under "fingerprint requirements".)
- Documentation demonstrating that you have completed the qualification requirements (described below).
- If you would like notification that the board has received your application, please submit a postage-paid postcard addressed to yourself.

PHARMACY TECHNICIAN

QUALIFICATION METHODS AND REQUIRED DOCUMENTS

Identify which of the following methods qualifies you for registration as a pharmacy technician, and submit the required document(s) for that method:

Method A - At least an associate of arts degree in a field of study directly related to the duties performed by a pharmacy technician. Directly related fields of study include; but are not limited to, health sciences, biological sciences, physical sciences, or natural sciences.

- An official transcript, indicating date of graduation and degree earned, must be sent DIRECTLY to the board's office from the school(s) you attended.

Method B - Completion of a training course accredited by the American Society of Health-System Pharmacists (ASHP); training provided by a branch of the federal armed forces; or any other course that provides a minimum of 240 hours of theoretical and practical instruction, provided that at least 120 of these hours are in theoretical instruction.

- If the course you attended was accredited by the American Society of Health-System Pharmacists (ASHP), submit the original certificate displaying the ASHP accreditation seal.

- If your training was provided by a branch of the federal armed services, submit the original or a certified true copy of your DD214.

- If you completed any other pharmacy technician training course, you must request that the course provider send us a transcript or other documentation indicating the date of completion and the number of hours completed in theoretical and practical instruction. Copies of diplomas cannot be accepted.

Method C - Eligible to take pharmacist licensure examination

- Identify yourself as being a candidate for the California pharmacist licensure examination on the face of the application.

Method D - At least one year of experience (to include a minimum of 1,500 hours) performing the tasks of a pharmacy technician as outlined in section 1793.2 of the California Code of Regulations in an inpatient hospital, correctional facility, federal installation, out-of-state retail or hospital pharmacy, or within the last three years, as a registered pharmacy technician in California.

- Experience affidavit (Form 17A-10) completed by the pharmacist(s) having direct knowledge of your experience certifying that you have completed a minimum of 1,500 hours performing the duties of a pharmacy technician in an inpatient hospital, correctional facility; federal installation, out-of-state retail or hospital pharmacy, or within the last three years, as a registered pharmacy technician in California.

  Experience noted on section D of the application must reflect the experience noted on the experience affidavit. Be sure to include month, day and year on both the application and experience affidavit. Do not write still employed, current or present.

  Experience earned more than three years prior to the date the Board receives your application cannot be used to fulfill the experience requirements as a registered pharmacy technician in California.

  If the qualifying experience was obtained in more than one pharmacy, each employer must complete an experience affidavit.

Method E - A minimum of 1,500 hours experience working in a community or outpatient pharmacy performing the duties of a clerk-typist, as specified in section 1793.3 of the California Code of Regulations.

- Equivalent experience affidavit(s) (Form 17A-6) certifying to the completion of at least 1,500 hours experience within the last three years in an outpatient or community pharmacy. The form must be completed by the pharmacist having direct knowledge of your experience.

  Equivalent experience earned more than three years prior to the date the Board receives your application cannot be used to fulfill the experience requirements as a registered pharmacy technician in California. Experience noted on section E of the application must reflect the experience noted on the experience affidavit. Be sure to include month, day and year on both the application and experience affidavit. Do not write “still employed”, “current” or “present.”

  If the qualifying experience was obtained in more than one pharmacy, each employer must complete an experience affidavit.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If you reside out of state, you must submit rolled fingerprints on cards provided by the board and include a separate fee of $42 ($32 California Department of Justice (DOJ) processing fee and $10 DOJ expedite fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request the fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

California code sections relating to pharmacy technician duties and required experience for registration as a pharmacy technician.

CALIFORNIA CODE OF REGULATIONS
DIVISION 17, TITLE 16
Article 12. Ancillary Personnel

1793.2. Duties of a Pharmacy Technician

Pharmacy technicians may perform packaging, manipulative, repetitive, or other non-discretionary tasks, while assisting, and while under the direct supervision and control of, a registered pharmacist. "Non-discretionary tasks" as used in Business and Professions Code section 4115, include:

a. removing the drug or drugs from stock;
b. counting, pouring, or mixing pharmaceuticals;
c. placing the product into a container;
d. affixing the label or labels to the container;
e. packaging and repackaging.

1793.3. Other Non-Licensed Pharmacy Personnel

In addition to employing a pharmacy technician to perform the tasks specified in section 1793.2, a pharmacy may employ a non-licensed person to type a prescription label or otherwise enter prescription information into a computer record system, but the responsibility for the accuracy of the prescription information and the prescription as dispensed lies with the registered pharmacist who initials the prescription or prescription record. At the direction of the registered pharmacist, a non-licensed person may also request and receive refill authorization. There shall be no more than one non-licensed person, other than a pharmacy technician, performing the tasks specified in this section for each registered pharmacist on duty.

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STATE AND CONSUMER SERVICES AGENCY
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APPLICATION FOR REGISTRATION AS A PHARMACY TECHNICIAN

Print or type

Name: Last	First	Middle	Former	TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION **NO POLAROID**
*Address of Record: Number	Street			
City	State	Zip Code		
Residence Address: (if different from above) Number	Street			
City	State	Zip Code		

Home telephone number ( )	Work telephone number ( )	Date of Birth	Social Security Number *

Email address

Have you previously applied for registration with the board as a pharmacy technician? Yes ☐ No ☐
If "yes," provide the date you applied:_____ Name applied under: _____

Have you previously been **registered** as a pharmacy technician? Yes ☐ No ☐
If "yes," complete the section below and then proceed to section D.

EDUCATION

Name of high school attended _____Location of school (city & state) _____

Graduate from high school Yes ___ Date: _____ GED ___ Date: _____

Name that appears on diploma or GED certificate _____

A/B EDUCATION/TRAINING

Name and address of university, college, school or organization	Date of completion/graduation	Degree/Name of course

C PHARMACIST EXAM

Are you eligible to take the California pharmacist licensure exam? Yes ☐ No ☐

If "yes," provide the date you applied:_____ Name applied under: _____

DO NOT WRITE BELOW THIS LINE

FP Cards ☐
Photo ☐
Exp Aff ☐
FP Clearance ☐
Transcript ☐

Training cert ☐
Hours verified_____
TC Code_____
Qualify Code_____

Registration No. _____
Date Issued _____

Application fee no. _____
Amount _____
Date Cashiered _____

* Once you are licensed with the board the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be placed on the Internet upon licensure. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is a box number you must also provide your residence address as an alternate address that will not be available to the public.

D **TECHNICIAN EXPERIENCE** –List all qualifying experience earned in and out of state performing the tasks of a pharmacy technician. If you have been registered previously as a pharmacy technician in California, provide your technician registration number and list experience earned as registered pharmacy technician in California.

California registered pharmacy technician number _____ Expiration date _____

Dates of employment		Name and address of employer(s)	Total hours experience	Name of pharmacist having direct knowledge of your experience
From	To			

E **EXPERIENCE** – List all qualifying experience earned in and out of state.

Dates		Name and address of employer(s)	Total hours experience	Name of pharmacist having direct knowledge of your experience
From	To			

You must provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete.

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks? **If "yes," attach a statement of explanation. If "no," proceed to #3**. Yes ☐ No ☐

2. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? **If "yes," attach a statement of explanation.** Yes ☐ No ☐

   If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted registration should be issued, whether conditions should be imposed, or whether you are not eligible for registration.

3. Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances? Yes ☐ No ☐

   If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **Attach a statement of explanation**. Yes ☐ No ☐

4. Has disciplinary action ever been taken against your pharmacist license, intern permit or technician registration in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

5. Have you ever had an application for a pharmacist license, intern permit or technician registration denied in this state or any other state? **If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes ☐ No ☐

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration, denied or disciplined by a governmental authority in this state or any other state? **If "yes," provide the name of company, type of permit, type of action, year of action and state.** Yes ☐ No ☐

7. Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code sections 1000 or 1203.4. Traffic violations of $500 or less need not be reported. **If "yes," attach an explanation including the type of violation, the date, circumstances, location and the complete penalty received.** Yes ☐ No ☐

8. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer or any other entity licensed in this state or any other state? If yes, provide company name, type of permit, permit number and state where licensed. Yes ☐ No ☐

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

_____ _____

Signature of applicant (in full—no initials) Date signed

All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the Executive Officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

* Disclosure of your U.S. social security account number is mandatory. Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security account number. Your social security account number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security account number your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

Under California law each person licensed by the Board of Pharmacy is a “mandated reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions.

California Penal Code section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine.

For further details about these requirements, consult Penal Code sections 11164, and following.

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Pharmacy Technician Equivalent Experience Affidavit
(For Outpatient or Community Pharmacy)

TO BE COMPLETED BY APPLICANT (please print or type)

Name of Applicant			Telephone Number ( )	
Residence Address	Street and Number	City	State	Zip Code

To be completed by the pharmacist having direct knowledge of applicant's experience

The individual applying for registration as a pharmacy technician in California based on EQUIVALENT experience obtained in an outpatient or community pharmacy has completed a minimum of 1,500 hours performing specific duties as a pharmacy clerk-typist **within the immediately preceding three years**. The specific duties are those listed in section 1793.3 of Division 17, Title 16 of the California Code of Regulations: typing prescription labels, entering prescription information into a computer system, or requesting and receiving refill authorizations.

(Please print or type)

_____ was employed as a pharmacy clerk-typist and was under the supervision of a registered pharmacist.
(Name of Applicant)

From _____ to _____ Number of hours_____
(month/day/year) (month/day/year)

DO NOT state "current/present or still employed"

Name and Address of Pharmacy

Name of Pharmacy			Pharmacy License Number	
Address of Pharmacy	Street and Number	City	State	Zip Code
Pharmacist Having Direct Knowledge	(please print)		CA Pharmacist License Number	

I certify under penalty of perjury under the laws of the State of California that all statements given herein are true, and that to the best of my knowledge the experience thus gained by this applicant has been predominantly related to the practice of pharmacy as required by law.

_____ _____ _____
Signature of Pharmacist Having Direct Knowledge of Applicant's Experience State Date

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Pharmacy Technician Experience Affidavit

TO BE COMPLETED BY APPLICANT (please print or type)

Name of Applicant			Telephone Number ( )
Residence Address Street and Number: 400 R Street Suite 4070	City: Sacramento, CA 95814	State	Zip Code

To be completed by the pharmacist having direct knowledge of applicant's experience

(Please print or type. Check one box)

The individual applying for registration as a pharmacy technician in California has completed at least one year of experience (to include a minimum of 1,500 hours) performing the duties of a **pharmacy technician** in an ☐ inpatient hospital; ☐ correctional facility; ☐ federal installation; ☐ out-of-state retail or hospital pharmacy or ☐ within the last three years, as a registered pharmacy technician in California.

_____ was employed as a **pharmacy technician** and was under
(Name of Applicant)

the supervision of a registered pharmacist performing the following duties as specified in section 1793.2 of Division 17, Title 16 of the California Code of Regulations: removing drugs from stock; counting, pouring, or mixing pharmaceuticals; placing the product into a container; affixing labels to container; packaging or repackaging.

From _____ to _____ Number of hours _____
(month/day/year) (month/day/year)

DO NOT state "current, present or still employed"

Name and Address of Pharmacy

Name of Pharmacy			Pharmacy License Number
Address of Pharmacy Street and Number	City	State	Zip Code
Name of Pharmacist Having Direct Knowledge (please print)		Pharmacist License Number	State

I certify under penalty of perjury under the laws of the State of California that all statements given herein are true, and that to the best of my knowledge the experience thus gained by this applicant has been predominantly related to the practice of pharmacy as required by law.

_____ _____
Signature of Pharmacist Having Direct Knowledge of Applicant's Experience Date

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://caag.state.ca.us/app/contact.pdf or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of $32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Technician - Section 4015

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95814
City State Zip Code

( ) 916-445-4014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Technician - Section 4015

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95814
City State Zip Code

( ) 916-445-4014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Technician - Section 4015

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

400 R Street Suite 4070
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95814
City State Zip Code

( ) 916-445-4014
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

( ) N/A
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed